CRITERIA FOR PRIOR AUTHORIZATION

Alpha Interferon

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Peginterferon alfa-2b (Sylatron®)

CRITERIA FOR INITIAL APPROVAL Must meet all of the following:

- Patient must have a diagnosis of melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy
- Must be prescribed by or in consultation with an oncologist
- Patient must be 18 years of age or older

LENGTH OF APPROVAL 1 year